DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 0 1

2. STATE: HAWAII

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
MEDICAL ASSISTANCE

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 C.F.R. Section 447.253

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ (463,590)
b. FFY 2002 $ (471,240)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A
Pages: 1, 4, 6, 8, 12, 22, 23, 26, 27
28, 34, 37, 38, 39

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A
Pages: 1, 4, 6, 8, 12, 22, 23, 26, 27,
28, 34, 37, 38, 39

10. SUBJECT OF AMENDMENT:
Methods and Standards For Establishing Payment Rates Prospective Reimbursement System For Inpatient Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Approved By Governor

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kathleen S Stanley for

13. TYPED NAME:
Susan M. Chandler, M.S.W., Ph.D.

14. TITLE:
Director

15. DATE SUBMITTED:
August 21, 2000

16. RETURN TO:
State of Hawaii
Department of Human Services
Med-QUEST Division
P.O. Box 339
Honolulu, Hawaii 96809-0339

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
August 28, 2000

18. DATE APPROVED:
November 22, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE OF HAWAII

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES PROSPECTIVE REIMBURSEMENT SYSTEM FOR INPATIENT SERVICES

I. GENERAL PROVISIONS

A. PURPOSE

This plan establishes a reimbursement system for acute care facilities which complies with the Code of Federal Regulations. It describes principles to be followed by Title XIX acute care providers in making financial reports and presents the necessary procedures for setting rates, making adjustments, and auditing the cost reports.

B. OBJECTIVE

The objective of this plan is to establish a prospective payment system that complies with the Balanced Budget Act of 1997, which requires that reimbursements be in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

C. REIMBURSEMENT PRINCIPLES

1. The Hawaii Medicaid Program shall reimburse Providers for inpatient institutional services based primarily on the prospective payment rates developed for each facility as determined in accordance with this Plan. In addition, certain costs (such as Capital Related Costs) shall be reimbursed separately. The estimated average proposed payment rate under this plan is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the Department reasonably estimates would be paid for those services under Medicare principles of reimbursement.

D. DEFINITIONS APPLICABLE TO THE PROSPECTIVE RATE SYSTEM

The following definitions shall apply for purpose of calculating prospective payment rates and adjustments for acute inpatient services:

1. "Acuity Level A" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care from a Nursing Facility relatively lower than Acuity Level C. Prior to October 1, 1990, that level of care was appropriately obtained from an ICF.

2. "Acuity Level C" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care from a Nursing Facility relatively higher than Acuity Level A. Prior to October 1, 1990, that level of care was appropriately obtained from an SNF.

3. "Adjustments" mean all adjustments to the Basic Per Diem, Basic Per Discharge and All-Inclusive Rates and/or the Capital Payments that are defined in this Plan and that are appropriate for a particular Provider. Those adjustments may include the GET Adjustment, the Medical Education Adjustment, and/or the Severity and Case Mix Adjustment.

4. "All-Inclusive Rates" means the separate per diem rates that are paid to Classification I and IV facilities for psychiatric and nonpsychiatric cases, and the per diem rates that are paid to Classification II and III facilities for psychiatric cases only. The All-Inclusive Rates are calculated to include reimbursement for both routine and ancillary costs.

5. "Ancillary Services" means diagnostic or therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board. Ancillary services generally are those special services for which charges are customarily made in addition to routine charges, and they include such services as laboratory, radiology, surgical services, etc.

6. "Base Year" means the State fiscal year used for initial calculation and recalculation of prospective payment rates. The Base Year shall be the most recent State fiscal year or years for which complete, finally-settled financial data is available. Base Year data shall be supplemented with finally-settled cost data from previous years, if it is determined that extraordinary costs occurred in the most recent, finally-settled cost report.

a. The patient is formally released from the hospital.

b. The patient is transferred to an out-of-state hospital.

c. The patient is transferred to a long-term care level or facility.

d. The patient dies while hospitalized.

e. The patient signs out against medical advice.

f. In the case of a delivery where the mother and baby are discharged at the same time, the mother and her baby shall be considered two discharges for payment purposes. In cases of multiple births, each baby will be considered a separate discharge.

g. A transfer shall be considered discharge for billing purposes but shall not be reimbursed as a full discharge except as specified in Section IV.B.6.a.

15. "Federal PPS" means the prospective payment system based upon diagnostic related groups ("DRGs") used by the Medicare program under Title XVIII of the Social Security Act to pay some hospitals for services delivered to Medicare beneficiaries.

16. "Inflation Factor" means the estimate of inflation in the costs of providing hospital inpatient services for a particular period as estimated in the DRI McGraw-Hill Health Care Costs: National Forecast Tables, PPS-Type Hospital Market Basket, or its successor. Effective with rate calculations for state fiscal years beginning July 1, 2000 and July 1, 2001, the inflation adjustment means one half of the estimate of inflation in costs of providing services for a particular period as estimated in the "Health Care Cost Review" published by Standard and Poor's DRI, a division of McGraw-Hill Companiesor its successor.

17. "Inpatient" means a patient who is admitted to an acute care facility on the recommendation of a physician or dentist and who is receiving room, board, and other inpatient services in the hospital at least overnight, and requires services that are determined by the State to be medically necessary. A patient who is admitted to an acute care facility and expires while in the facility shall be considered an inpatient admission

fiscal year beginning July 1, 1994, the Outlier Threshold is $53,000. Effective with the State fiscal years beginning July 1, 2000 and July 1, 2001, the Outlier Thresholds are increased by the inflation factor resulting in an Outlier Threshold of $64,000 for the State fiscal year beginning July 1, 2000.

25. "Outpatient" means a patient who receives outpatient services at a hospital which is not providing the patient with room and board and other inpatient services at least overnight. Outpatient includes a patient admitted as an inpatient whose inpatient stay is not overnight, except in cases where the patient expires in the facility.

26. "PPS" means the prospective payment system that is established by this Plan.

27. "Plan" means this document.

28. "Proprietary Provider" means a Provider that is organized as a for-profit entity and is subject to state general excise and federal income taxes.

29. "Provider" means a qualified and eligible facility that contracts with the Department to provide institutional acute care services to eligible individuals.

30. "Rebasing" means calculating the Basic PPS Rates by reference to a new Base Year and new Base Year Cost Reports.

31. "ROE/GET Adjustment" means the adjustment to the All-Inclusive, Basic Per Diem and Basic Per Discharge Rates to provide Medicaid's fair share of a return on the investment that a Proprietary Provider has made in its facility and for Medicaid's fair share of the general excise taxes that it pays the State of Hawaii, as calculated under this Plan. Effective with SFY beginning July 1, 2000, ROE adjustments are eliminated from the PPS rate calculation..

32. "Routine services" means daily bedside care, such as room and board, serving and feeding patients, monitoring life signs, cleaning wounds, bathing, etc.

33. "Severity and Case Mix Adjustment" means an increase of 2% to the All-Inclusive Rate of the Classification IV facility.

2. Facility classification changes shall only be recognized at the time of a Rebasing. If a facility changes classification in accordance with the definitions above, then rates established under this Plan shall continue to apply until the Rebasing. A facility that adds an approved intern and resident teaching program, however, may seek rate reconsideration under Section V.C.1.c. (Note: Effective with SFY beginning July 1, 2000, rate reconsideration provisions have been eliminated).

C. SERVICE CATEGORY DESIGNATIONS

1. Services provided by acute inpatient facilities shall be classified into four mutually exclusive categories:

a. Maternity - An inpatient stay which results in a delivery with a maternity principal or secondary diagnosis code;

b. Surgical - An inpatient stay with the following characteristics:

(1) the claim has not been classified as a maternity claim;

(2) the claim includes a surgical code that is considered to be an operating room procedure in the latest and most current version of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM); and

(3) the claim includes either:

(a) a surgical date; or

(b) an operating room charge.

c. Psychiatric - An inpatient stay with a primary psychiatric principal diagnosis code and with no operating room charge; or

d. Medical - An inpatient stay not classified into one of the above three service categories.

(3) The Department shall review the estimates for reasonableness and determine an amount of projected allowable Capital Related Costs for each facility.

(4) The projected allowable Capital Related Costs (less 10%) shall be divided by 12.

(5) The product of the foregoing computation shall, at the Department's option, be multiplied either by the facility's projected Medicaid utilization rate or by the facility's actual Medicaid utilization (based upon the ratio of Medicaid patient days to total patient days) reflected in the most recently filed cost report.

(6) The net result shall constitute the interim Capital Payment, which shall be paid on a monthly basis throughout the fiscal year.

b. The final Capital Payment shall be determined as follows:

(1) After the end of the fiscal year, the Department shall adjust and settle the Capital Related Costs of each facility based upon information reflected in the finally settled cost reports that cover the fiscal year under review.

(2) Capital Related Costs shall follow the Medicare PPS capital pass through methodology in 42 C.F.R. Part 413, Subpart G, as of 10/1/87 .

(3) A provider may appeal the Department's final settlement of Capital Related Costs in accordance with the procedural requirements of Chapter 17-1736 of the Hawaii Administrative Rules (see appendix to state plan). The Department

may settle tentatively on the Capital Related Costs.

3. For Proprietary Providers, the ROE Adjustment, which represents a hospital's percentage of return on equity received in the Base Year under Medicare cost reimbursement principles, shall be determined as follows:

   a. Divide the total allowed Medicaid inpatient return on equity amounts by allowed Medicaid inpatient total costs; and

   b. The results shall be added to 1.00 to obtain the return on equity adjustment factor.

   Note: Effective with SFY beginning July 1, 2000, the ROE adjustment is eliminated from the PPS rate calculation..

4. All Providers that participate in an approved teaching program shall receive the Medical Education Adjustment, calculated as follows:

   a. Divide allowed Medicaid inpatient medical education costs by total allowed Medicaid inpatient total costs; and

   b. The result shall be added to 1.00 to obtain the medical education adjustment factor.

   c. For New Providers, the medical education factor shall be determined as part of the rate reconsideration process as authorized in Section V.C.1.c. (Note: The Rate reconsideration process has been eliminated effective with the state fiscal year beginning July 1, 2000).

E. FINAL PROSPECTIVE PAYMENT CALCULATIONS

1. Based on the PPS rates as adjusted in Section III.D. above and inflated in Section III.G. below, a facility's payment for each inpatient stay in each classification shall be calculated as follows:

   a. For psychiatric discharges, multiply the Total All-Inclusive Rate for a psychiatric discharge by the number of days of the psychiatric inpatient stay. The result shall be the payment for a psychiatric discharge;

by dividing total nonpsychiatric costs, excluding Capital Related Costs, for the hospital by nonpsychiatric Medicaid patient days.

d. The facility specific factors shall be computed or reimbursed as defined in Section III. D.

G. ADJUSTMENT TO BASE YEAR COSTS FOR INFLATION

Cost increases due to varing fiscal year ends and inflation shall be recognized for purposes of establishing prospective payment rates in accordance with the following general methodology. Effective with rate calculations for state fiscal years beginning July 1, 2000 and July 1, 2001, the inflation adjustment means one half of the estimate of inflation in cost of providing services for a particular period as estimated in the "Health Care Cost Review" published by Standard and Poor's DRI, a division of McGraw-Hill Companies or its successor.

1. Base year facility-specific costs shall be standardized to remove the effectscaused by varing fiscal year ends of the facility. This shall be accomplished by dividing the Inflation Factor for the Base Year, as determined in accordance with Section II.A.3. by 12 and multiplying this result by the number of months between the hospital's Base Year fiscal year end and June 30 of each year. This result shall be added to 1.00 to yield an inflation adjustment factor which shall then be multiplied by the facility-specific costs.

2. Cost increases due to inflation which occurred from the Base Year shall utilize the inflation factor specified in Section II.A.3.

3. For years in which the Department does not Rebase the PPS rates, cost increases due to inflation shall be recognized by multiplying the Total All-Inclusive, Total Per Diem and Total Per Discharge Rates in effect for the fiscal year by one plus the Inflation Factor for the following fiscal year. To insure the prospective nature of the PPS, the inflation factor shall not be retroactively adjusted nor modified, except as noted below.

4. For years in which the Department does not Rebase and in which the Inflation Factor for the prior year was reduced prusuant to Section III.G.6.,

then the average rates for the prior fiscal year shall be deemed to be the rates in effect on June 30.

5. For each year in which the Department does Rebase, cost increases due to inflation shall be recognized by multiplying the Base Year rates by one plus the Inflation Factor for each subsequent year, using the most current and accurate Inflation Factor data then available. To insure the prospective of the PPS, that data shall not be retroactively adjusted nor modified.

6. Absent circumstances beyond the control of the Department before the expiration of six months in each fiscal year the Department shall determine whether the aggregate amount of reimbursement for the state fiscal year is projected to exceed the amount that would be paid for the same services under Medicare principles of reimbursement. In making the determination, the Department shall exclude sums paid pursuant to Section III.D.1. or any exception to or exemption from the ceilings on rate of hospital cost increases as defined pursuant to 42 C.F.R. Part 413. In making its determination, the Department shall use the most current information available, including the most recent cost reports filed by the facilities. If the projected aggregate amount of reimbursement is reasonably anticipated to exceed the amount that would be paid under Medicare principles of reimbursement, then the Department shall reduce the Inflation Factor used to calculate the rates for the remainder of the fiscal year so that the aggregate payments for the entire fiscal year are reasonably projected to be no more than that which would be paid under Medicare principles of reimbursement.

IV. SPECIAL PAYMENT PROVISIONS

A. TREATMENT OF NEW FACILITIES

1. Rates for new Providers shall be calculated by a separate method. A New Provider shall receive a statewide weighted average payment rates for

its classification times the following New provider adjustment factor:

a. First Operating Year 150%;

b. Second Operating Year 140%;

c. Third Operating Year 130%; and

d. Fourth Operating Year and thereafter 125%.

e. If a facility's Operating Year does not coincide with the PPS fiscal year, then the New Provider's rates shall be prorated based on the PPS fiscal year. For example, a New Provider that begins its First Operating Year on January 1 would receive 145% of the statewide weighted average payment rates for its classification for the entire PPS fiscal year that begins on the immediately following July 1.

2. Capital Related Costs shall be reimbursed as defined in Section III.D.2 and 3.

3. For New Providers that are also Proprietary Providers, the PPS rates shall also be adjusted by a GET Adjustment, (Section III.D.3.). This adjustment shall be based on projected costs and receipts and calculated as defined in this Plan (Note: Effective with state fiscal years beginning July 1, 2000 ROE is not included in the rate calculation).

4. A New Provider may seek rate reconsideration under Section V.C.1.c if it adds an approved intern and resident teaching program (Note: Effective with state fiscal years beginning July 1, 2000, the rate reconsideration process has been eliminated).

5. Notwithstanding the foregoing, a Provider that begins operations after January 1, 1993, shall receive the statewide weighted average per diem and per discharge rates for its classification.

6. A New Provider shall have its PPS rates determined under this section until a Rebasing occurs that identifies a Base Year in which the New Provider has a cost report that reflects a full twelve months of operations. Thereafter, its PPS rates

or due to appeals of audit and adjustment made to costs reported on the based year cost report, shall not result in changes to the rate ceiling or classification group.

2. Base Year costs shall be adjusted to reflect the audit and appeal decisions, and the facility's specific prospective rates (including the impact of all adjustment factors) and reimbursement for Capital Related Costs rate shall be recalculated, effective the first day of the initial rate year in which those costs were used to compute the PPS rate, based on the adjusted Base Year cost, as long as the rate ceilings are not exceeded.

B. REBASING THE PROSPECTIVE PAYMENT RATES

The Department shall perform a Rebasing periodically so that a Provider shall not have its Basic per Diem and Per Discharge Rates calculated by reference to the same Base Year for more than eight state fiscal years; provided, however, that the duty to Rebase shall be suspended during the period that the 1115 research and demonstration waiver is in existence and for one state fiscal year thereafter.

C. REQUESTS FOR RATE RECONSIDERATION (This section applied to State Fiscal Years ending on or prior to June 30, 2000. As of July 1, 2000 , rate reconsideration provisions have been eliminated. Providers may appeal their rate notifications by filing an appeal in accordance with the procedural requirements of Chapter 17-1736 of the Hawaii Administrative Rules).

1. Acute care providers shall have the right to request a rate reconsideration if one of the following conditions has occurred since the Base Year:

   a. Extraordinary circumstances, including but not limited to acts of God, changes in life and safety code requirements, changes in Licensure law, rules or regulations, significant changes in case mix or the nature of service, or addition or new services occurring subsequent to the Base Year. Mere inflation of costs, absent extraordinary circumstances, shall not be grounds for rate reconsideration.

   b. Reduction in Medicaid average length of stay within a facility which produced a decrease in the average cost per discharge but an increase in the average cost per day. This paragraph shall not include reductions in average length of stay resulting from a change in case mix. The rate reconsideration

a. A presentation of data to demonstrate reasons for the hospital's request for rate reconsideration.

b. If the reconsideration request is based on changes in patient mix, then the facility must document the change using diagnosis related group case-mix index or other well-established case-mix measures, accompanied by a showing of cost implications.

4. A request for reconsideration shall be submitted within 60 days after the prospective rate is provided to the facility by the Department or at other times throughout the year if the Department determines that extraordinary circumstances occurred. The addition of an approved intern and resident teaching program shall be one example of that type of extraordinary circumstance that justifies a mid-year rate reconsideration request.

5. The provider shall be notified of the Department's discretionary decision in writing within a reasonable time after receipt of the written request.

6. Pending the Department's decision on a request for rate reconsideration, the facility shall be paid the prospective payment rate initially determined by the Department. If the reconsideration request is granted, the resultant new prospective payment rate will be effective no earlier than the first date of the prospective rate year.

7. A provider may appeal the Department's decision on the rate reconsideration. The appeal shall be filed in accordance with the procedural requirements of Chapter 17-1736, administrative rules (see appendix to state plan).

8. Rate reconsiderations granted under this section shall be effective for the remainder of the prospective rate year. If the facility believes its experience justifies continuation of the rate in subsequent rate years, it shall submit information to update the documentation specified in subsection 2 within 60 days of

the notice of the facility's rate for each subsequent rate year. The Department shall review the documentation and notify the facility of its determination as described in subsection 4 above.

9. The Department may, at its discretion, grant a rate adjustment which is automatically renewable until the Base Year is recalculated.

10. Rate increases will be paid as a lump-sum amount.

VI. REPORTING REQUIREMENTS

A. COST REPORTING REQUIREMENTS

1. All participating acute care facilities shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles.

2. Participating facilities shall submit the following on an annual basis no later than five months after the close of each facility's fiscal year:

   a. Uniform Cost Report;
   b. Working Trial Balance;
   c. Provider Cost Report Questionnaire;
   d. Audited Financial Statements if available; and
   e. Disclosure of Appeal Items Included in the Cost Report.
   f. A listing of all Medicaid credit balances showing information deemed necessary by the State, and copies of provider policies and procedures to review Medicaid credit balances and refund overpayments to the State.

3. Claims payment for services will be suspended 100 percent until an acceptable cost report submission is received. A 30 day maximum extension will be granted upon written request only when a provider's operations are significantly adversely affected due to extraordinary circumstances beyond the control of the provider, as provided in Medicare guidelines.

4. Each provider shall keep financial and statistical records of the cost reporting year for at least

six years after submitting the cost report to the Department and shall also make such records available upon request to authorized State or federal representatives.

B. AUDIT REQUIREMENTS

1. The Department or its fiscal agent shall conduct periodically either on-site or desk audits of cost reports, including financial and statistical records of a sample of participating Providers in each Provider classification.

2. Reports of the on-site or desk audit findings shall be retained by the Department for a period of not less than three years following the date of submission of the report.

3. Each Provider shall have the right to appeal audit findings in accordance with the procedural requirements of Chapter 17-1736 of the Hawaii Administrative Rules (see appendix to state plan).

VII. WAITLISTED PATIENTS

A. Payments for waitlisted patients shall reflect the level of care required by the patient. The facility shall receive a routine per diem for each day that a waitlisted patient remains in the acute care part of the facility. Room and board waitlisted rates are to be determined based upon the statewide weighted average costs of providing either Acuity Level A or C services by distinct part facilities per the Medicaid long term care prospective payment rate calculations with the following exceptions:

1. The waitlisted rates cannot exceed the facility's own distinct part Acuity Level A or C prospective payment rates.

2. A facility with a distinct part SNF, but no ICF, would have an Acuity Level A waitlisted rate based on the statewide weighted average (but not to exceed the facility's distinct Acuity Level C PPS rate).

3. In no case will any relief granted under rate reconsideration be used to adjust the waitlisted rates.